



Medicaid Eligibility Determination and Non-Emergency Transportation

Senate Finance Committee
HHR Subcommittee

In this presentation

Determining Eligibility in Virginia's Medicaid Program

Performance and Pricing of Medicaid Non-Emergency Transportation

Enrollees must meet categorical, non-financial, and financial eligibility criteria

Eligibility category	Income threshold (% of FPL)	Asset limit	Non-financial criteria
Parents	24-48%	None	<ul style="list-style-type: none"> • Identity/SSN • Citizenship • Virginia residency
Children	143		
Pregnant women	143		
Aged	80	\$2,000/\$3,000	
Disabled/Blind	80	\$2,000/\$3,000	

Note: Table includes only full-benefit eligibility categories. FPL = Federal Poverty Level.

Accurate determinations require complete information and sound policies

- Complete, reliable information required to support eligibility determinations
- Sound policies and systems required to evaluate information against criteria
- Correct implementation of policies required to ensure accurate determinations

Finding

Most eligibility criteria are verified electronically more frequently due to implementation of new eligibility determination system and the availability of the federal hub; electronic verification of assets remains limited.

Electronic verification of assets remains limited

- Inconsistent availability of searchable real estate records
- Access to records from limited number of financial institutions
- No requirement for financial institutions to participate in new Asset Verification System

Note: Asset limit only applies to aged, blind, and disabled (ABD) applicants.

Recommendation

General Assembly may wish to consider:

- mandating that financial institutions participate in the Asset Verification System
- directing DSS to develop the capability to search for nationwide real estate assets through VaCMS

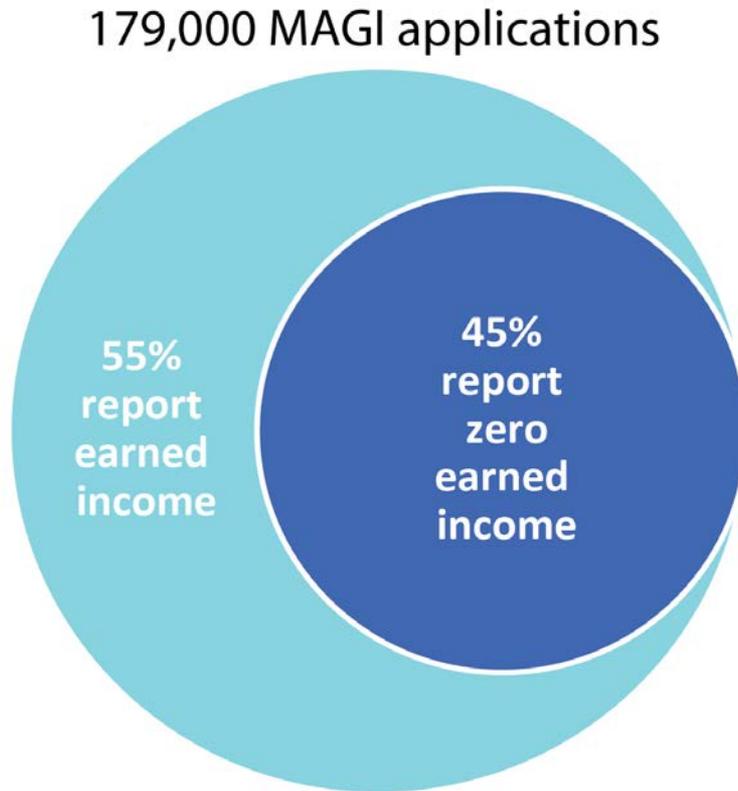
Findings

Virginia risks enrolling ineligible individuals in Medicaid because current policies do not ensure that all recipients meet financial eligibility criteria.

State risks enrolling ineligible individuals by not verifying zero income

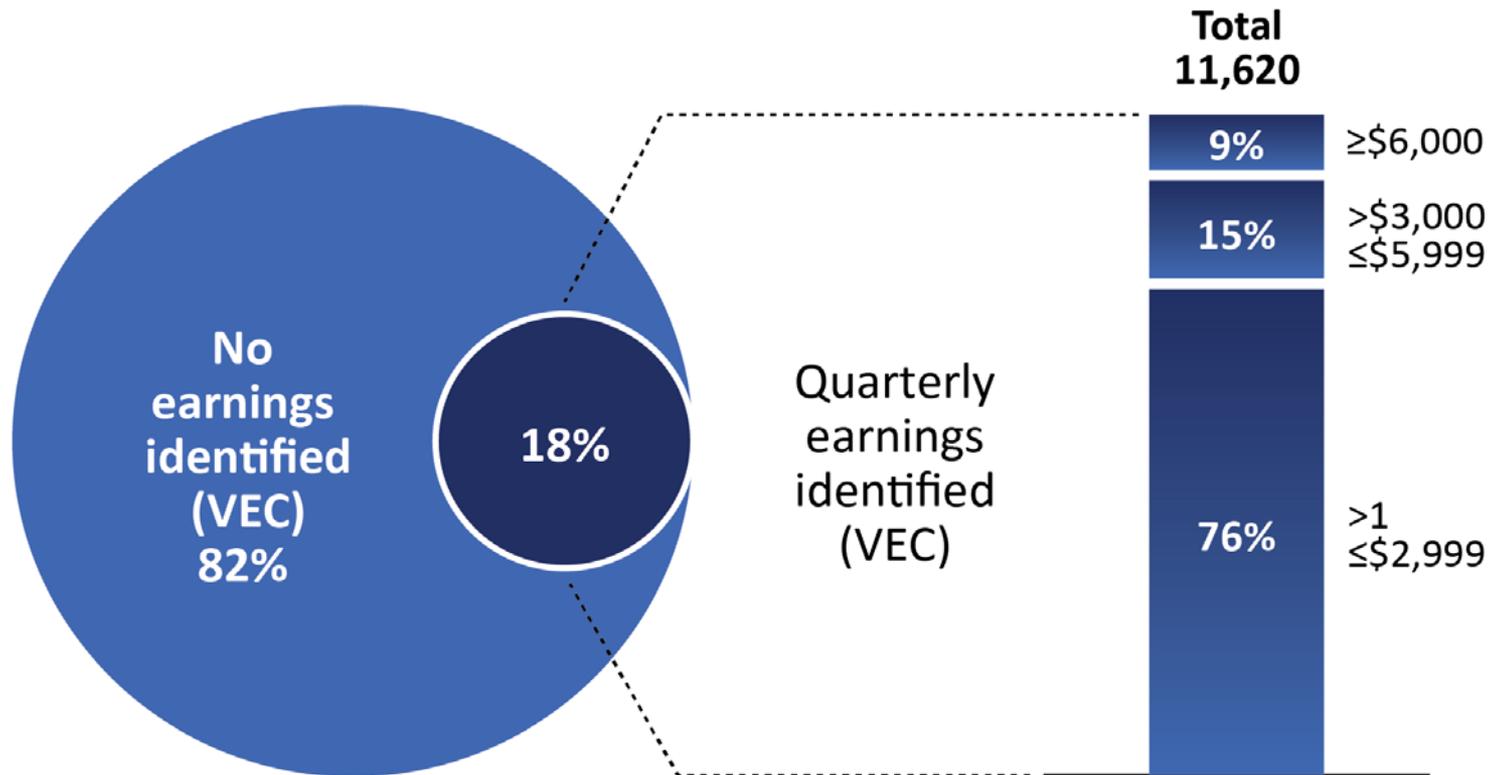
- Policy does not require eligibility workers to independently verify zero income
 - Applications bypass electronic verification
 - Verification occurs only if information appears questionable to the eligibility worker
- Self-attestation accepted from applicants or recipients

Almost half of approved MAGI applications reported zero earned income



Note: Includes all approved MAGI applications submitted between October 2013 and March 2015.

Wages identified in 18% of MAGI applications that weren't checked for earned income



Note: Includes all approved MAGI applications where earned income was not verified.

State risks enrolling ineligible individuals by not searching for unreported assets

- Policy does not require eligibility workers to search for unreported assets
 - No searches conducted unless information appears questionable to the eligibility worker
 - Some eligibility workers report conducting searches but practice is inconsistent
- Verification required only for reported
 - Assets that are not reported are unlikely to be identified

Note: Asset limit only applies to aged, blind, and disabled (ABD) applicants.

Recommendations

General Assembly may wish to consider:

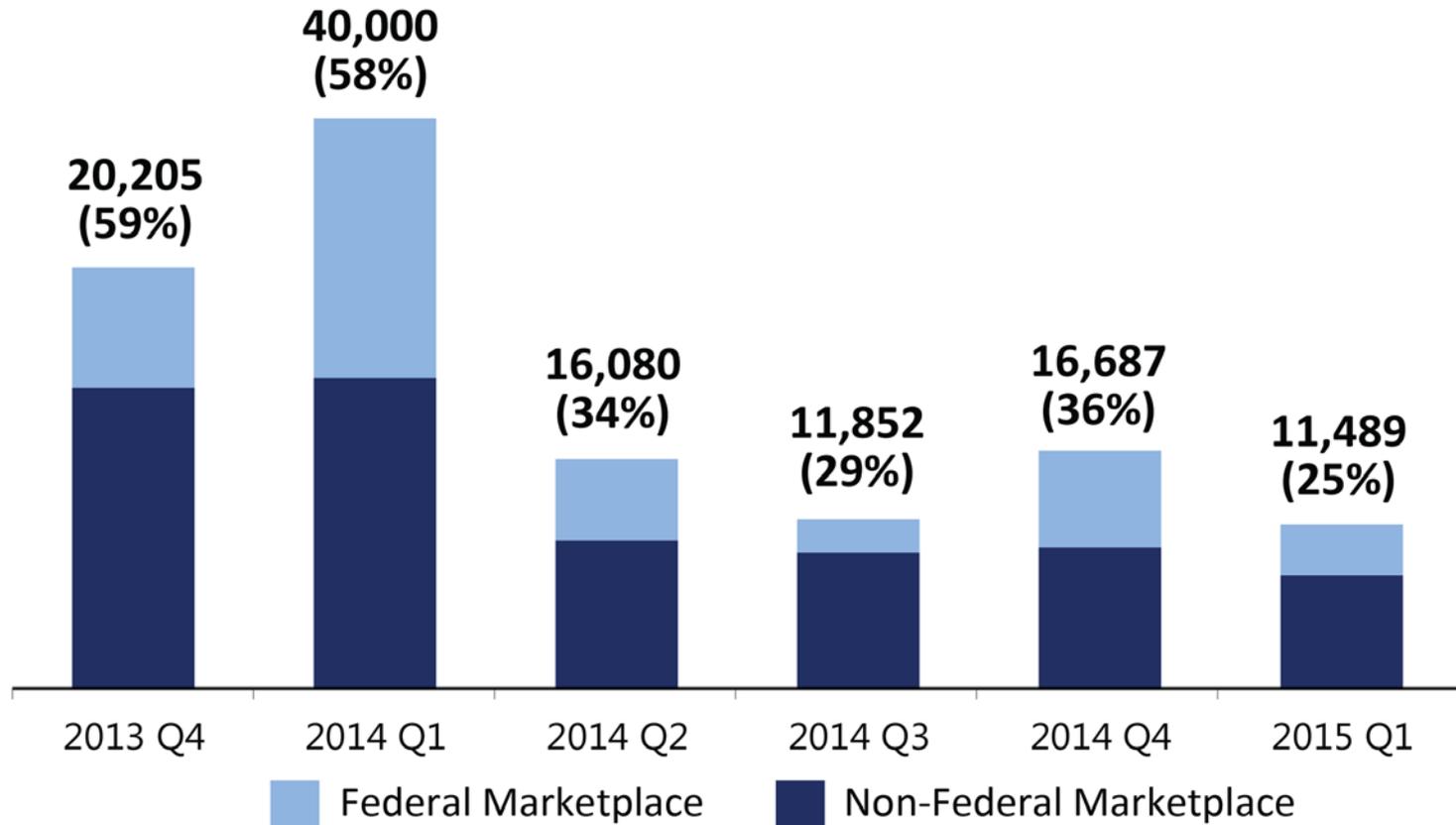
- requiring DMAS to apply income verification policies to all applicants
- requiring DMAS to mandate searching for unreported assets using available resources

Policy prescribes time standards for determining eligibility

Eligibility category	Days to process applications	Months to process renewals
Pregnant women	10	N/A
Parents & children	45	12 months
Aged	45	
Disabled/Blind	90	

Note: Applications from pregnant women must be processed in 10 working days.

Percentage of applications approved late decreased during 2014 but remains high



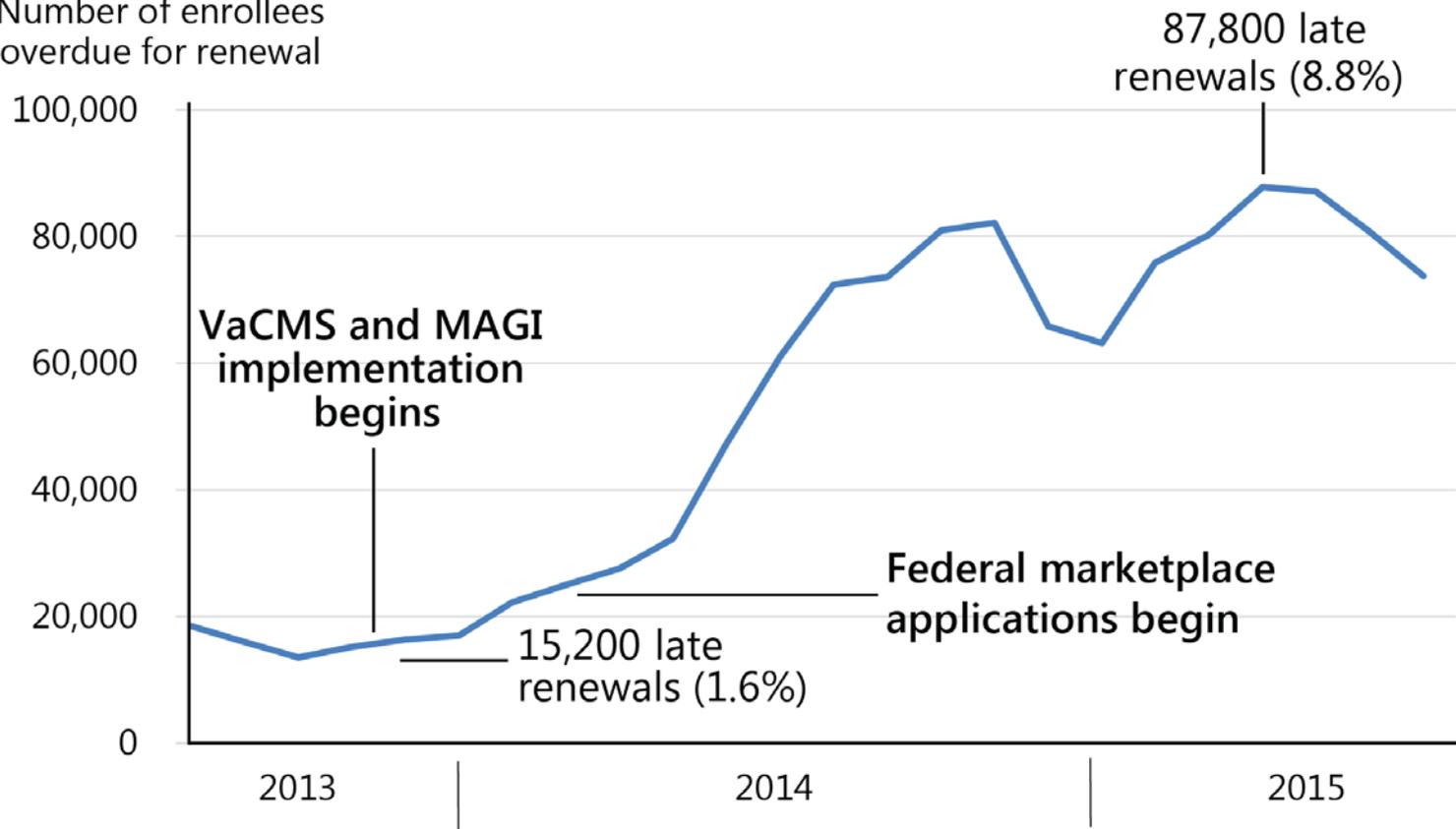
Note: Includes all MAGI applications submitted between October 2013 and March 2015.

Finding

Late renewals increased by nearly 500 percent between October 2013 and March 2015, resulting in \$21M to \$38M in estimated spending on ineligible recipients.

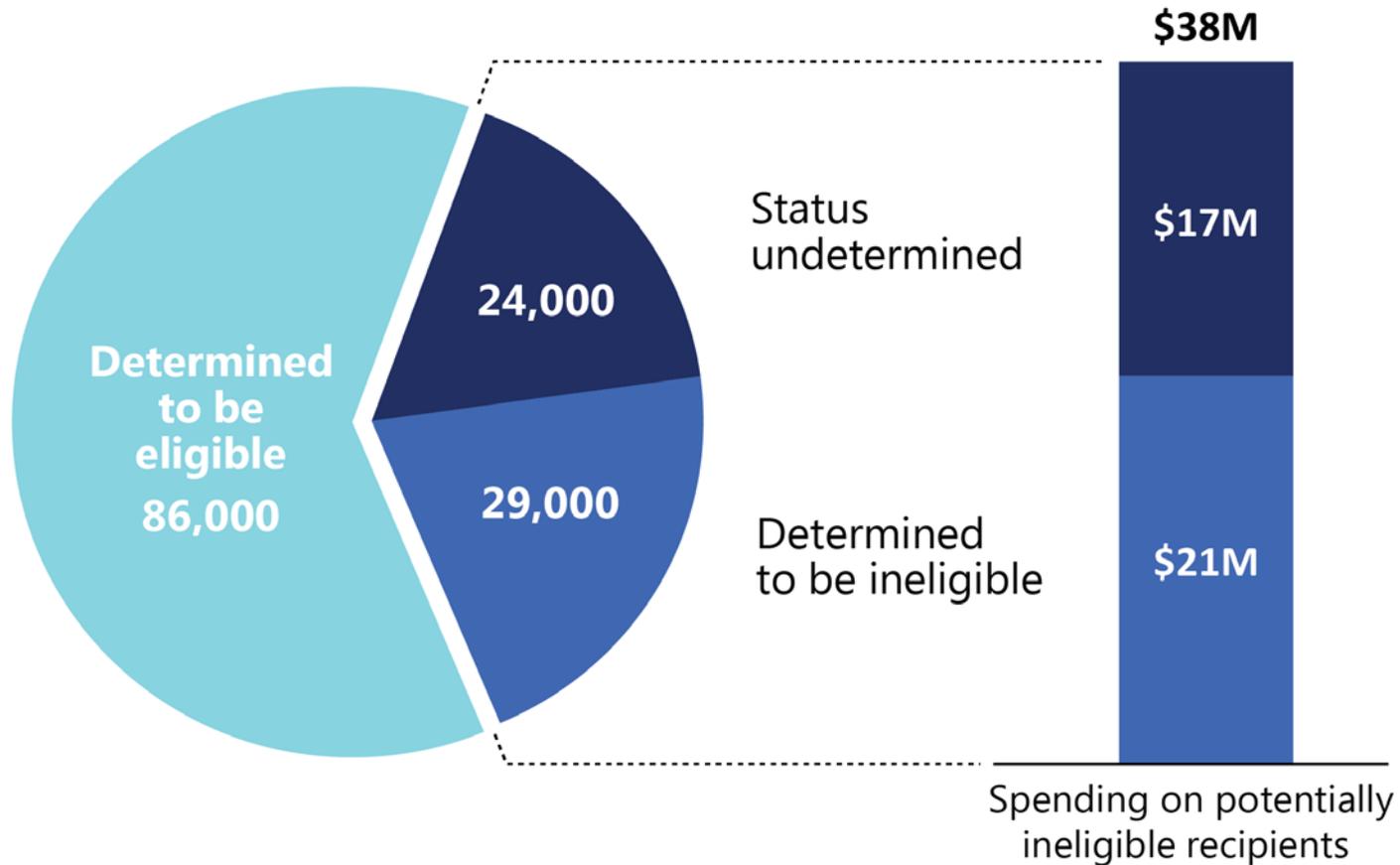
Late renewals increased by more than 70,000

Number of enrollees
overdue for renewal



Note: Includes all late Medicaid recipients.

Overdue renewals led to \$21M to \$38M in spending for ineligible recipients (FY 2014)



Using CPU for late renewals would generate cost savings for the state

- State could save between \$60 and \$115 per late renewal performed by the CPU
- Expanding CPU would require an estimated \$3.5 million investment (90 percent federally matched)
- State could save \$4 million assuming CPU performs 2,000 additional late renewals per month



Recommendations

The General Assembly may wish to consider expanding the CPU in the short term

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Finding

Virginia's NEMT performance improved temporarily after new performance standards were adopted in 2012, but the broker has since missed some critical performance measures, including complaints and unfulfilled trips.

Recommendations

The Department of Medical Assistance Services should require in the next NEMT contract:

- Steps to reduce late and unfulfilled trips (backup drivers, GPS routing system)
- Performance standard to ensure on-time arrival for vulnerable and medically fragile recipients

NEMT services paid on basis of fixed capitated rates

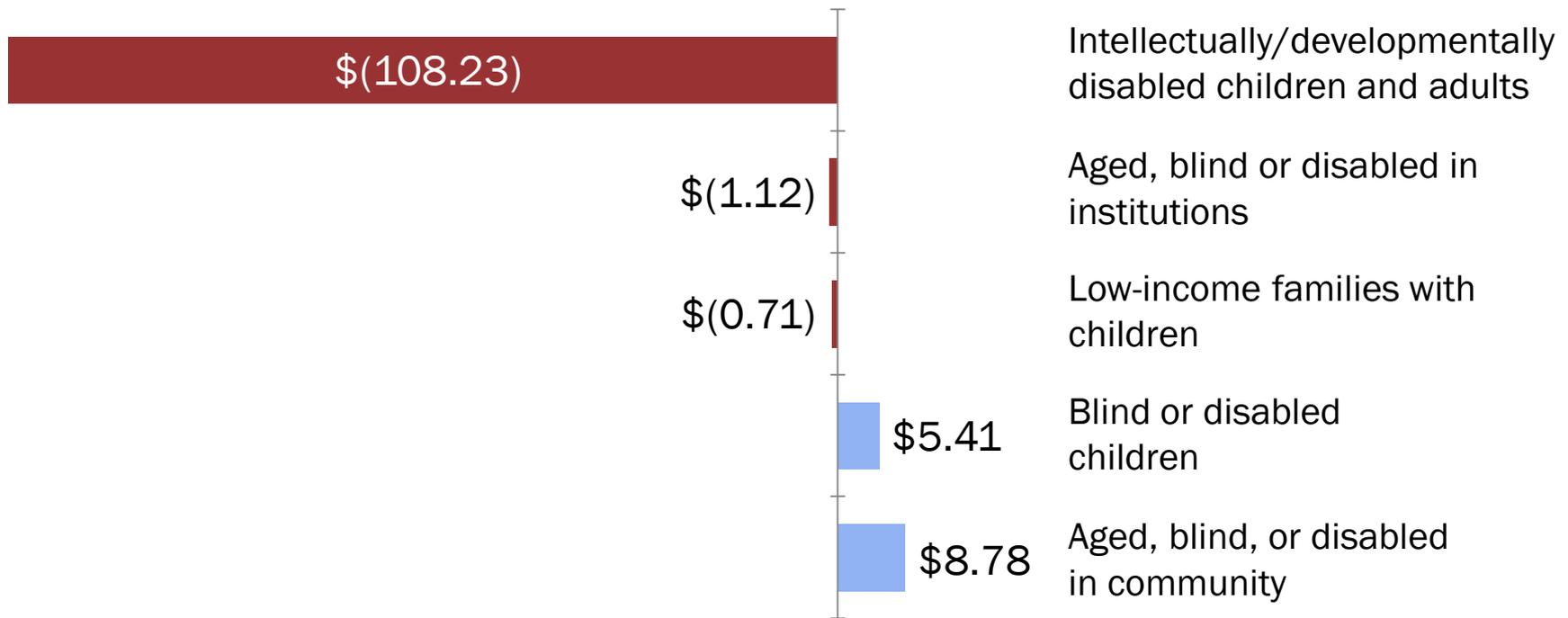
- DMAS pays broker a monthly rate for each enrollee
- Different rates set for major enrollee categories
- Rates established for entire contract period (up to 6 years)

Finding

NEMT rate-setting process reduces the state's leverage over the contracting process, increases financial risk, and could result in disruption of service delivery.

NEMT rates did not match costs for most recent contract period and resulted in loss for broker

Monthly profit/loss per enrollee by category (2012)



Source: Myers and Stauffer audit report, August 2014.

Current rate-setting process creates financial risk and limits state's leverage

- Establishing rates for entire contract period does not account for changes in cost or population
- Lack of reliable rate-setting data limits state's negotiating leverage and ability to establish appropriate rates
- Service could be disrupted if new rates are not agreed to

Recommendations

The Department of Medical Assistance Services should:

- Obtain reliable trip-level data and administrative cost data that can be used to set rates
- Implement financial risk-corridors limiting profit and loss, and set rates proactively
- Initiate a new NEMT contract to implement performance and rate-setting changes

Questions?

For more information...

<http://jlarc.virginia.gov>

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